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October 28, 2010

To: Supervisor Gloria Molina, Chair
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From: William T Fujioka
Chief Executive Officer

DEPARTMENT OF HEALTH SERVICES - INDEPENDENT REVIEW SERVICES: MEDICAL MALPRACTICE AND RISK MANAGEMENT STUDY IMPLEMENTATION PLAN

On August 17, 2010, your Board instructed the Chief Executive Officer (CEO), in conjunction with the Department of Health Services' (DHS) Chief Medical Officer and Quality Improvement team, to develop an implementation plan to execute the most significant issues addressed in the Abaris Group (Abaris) report dated August 13, 2010, and report back to your Board within 60 days with a plan and timetable for full completion of the 11 tasks described below.

As requested by your Board, a detailed Medical Malpractice and Risk Management Study Implementation Plan (Plan) has been completed and includes implementation strategies, comments, timeline, and status (Attachment).

BACKGROUND

As part of the Independent Review Entity process, Abaris completed a pilot study project which involved a comprehensive assessment of the current operation of DHS' Medical Malpractice and Quality Improvement Unit for the delivery of medical services to reduce risks of County liability. On August 17, 2010, the study findings and recommendations were presented to your Board. As noted by your Board, DHS has made significant progress in the reduction of medical malpractice and improved patient safety. DHS' efforts were also recognized for developing and improving their quality assurance system. To continue to build upon such efforts, your Board called for the development of the Plan to implement 11 tasks.

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Recognizing the importance of this effort and to ensure accountability in the implementation of the tasks, a lead representative/section was identified. Additionally, work on all 11 tasks has been initiated and three tasks have been completed. The tasks identified in your Board's motion addressed several areas, including patient safety, policy and procedure, and organizational structure. As noted, the detailed Plan is attached; it includes efforts completed thus far and is summarized below by area of improvement.

PATIENT SAFETY

Tasks 2, 8, 9, 10, and 11: create a database to track patient safety trends among all facilities, including a dashboard; create a public "Quality and Patient Safety" website; define goals and evaluate each County hospital against established state and national standards; engage focus group of patient care advocates (PPAs) to help develop dashboard presentation; and promote public reports designed to be meaningful to the general public as well as professionals.

The status and implementation highlights for the noted patient safety tasks are as follows:

- Task 2 Underway – Patient Safety Trend Database: a database for tracking patient safety trends will be implemented in two phases. Phase I of the project will include the assessment of existing resources and needs and development of a comprehensive design plan – targeted for December 2010. Phase II will include system acquisition and implementation – target date to be determined upon completion of Phase I. It should be noted that acquisition of the system will pose a financial challenge to DHS due to their budget deficit.

- Task 8 Underway - Quality and Patient Safety Website: implementation of this website included active stakeholder participation, including involvement from PPAs. Input from PPAs was integrated, and the website was presented to the PPAs, Hospital Commission, and Health Deputies. The website go-live date is November 15, 2010.

- Task 9 Underway – Evaluate County Hospitals: through the restructuring of DHS' Quality, Patient Safety and Clinical Risk Reduction Committee (Committee), new organizational priorities will be established for quality, patient safety, and clinical risk reduction. Additionally, the Committee will coordinate and oversee the function of various groups that currently work in silos. Committee will measure hospital specific and aggregate data against national, state, and benchmark affiliates – targeted for

November 2010. Please refer to Task 4 – Facility and Quality Improvement and Patient Safety (QIPS) Staff.

- Task 10 Underway – Dashboard: establish focus group of PPAs to assist with the development of the dashboard to ensure its information is clear, understandable, and timely. The dashboard should include a narrative that explains, to the general public, the significance of the data being presented and the actions taken should we ever fall below acceptable standards. PPAs were engaged in the development of the dashboard, and the go-live date is November 15, 2010.

- Tasks 11 Underway – Public Access: promote concept that public reports must be designed to be meaningful to the general public as well as professionals and use focus group to guide DHS. DHS, in partnership with PPAs, developed and implemented a core set of principles to guide the presentation of public reports.

  Core principles address dashboard goals (transparency, accountability, service quality, patient safety culture, and facilitate healthcare choices), guidelines that selection and presentation of quality and patient safety measures (benchmarks must be endorsed by a recognized national or state healthcare quality consensus body such as the National Quality Forum or the California Hospital Assessment and Reporting Taskforce); and basic tenets (dashboard must be meaningful to general public and development will involve PPAs). The QIPS website and dashboard go-live date is November 15, 2010.

POLICY/PROCEDURE

Tasks 1, 3, 4, and 7: Close the loop on the corrective action plan (CAPs) process by ensuring DHS tracks implementation and effectiveness; review the CAP preparation process and expedite the processing time; improve coordination between patient safety staff at facilities and DHS' QIPS staff; and increase accountability of physicians and other medical staff who fail to follow policies and patients are harmed as a result.

The status and implementation highlights for the noted policy and procedure tasks are as follows:

- Task 1 Completed - Close CAP Loop: the "closing the loop" process refers to ensuring that corrective actions listed in the CAPs and the associated system-wide surveys are validated and "implemented" once the CAP process has been completed. QIPS staff will conduct on-site audits to confirm implementation and the process will be recorded and tracked using a database. It should be noted that

DHS-QIPS does not currently have the necessary staff to perform the proposed function, please refer to Task 6 – QIPS' Staffing Plan.

- Task 3 Completed –Expedited CAPs: DHS and CEO processes were reviewed, and it was determined that both processes are necessary as they address different areas; no overlap was noted. However, the analysis did indicate that the processes were sequential thereby prolonging the review. The process has been revised and reviews are now conducted concurrently, which has expedited the process by reducing the overall time by two weeks.

- Task 4 Underway – Facility and QIPS Safety Staff: DHS will implement better coordination between patient safety staff at clinic sites and QIPS safety staff in two phases and will include an oversight committee and an educational program. Phase I calls for the restructuring and creation of the DHS-Quality, Patient Safety and Clinical Risk Reduction Committee – targeted for November 2010. Phase II will involve development of a uniformed and standardized curriculum of basic patient safety education – targeted for April 2011.

- Task 7 Completed – Physicians and Medical Staff Accountability: DHS' policy #311.202 includes specific language related to holding all staff accountable. DHS is also in the process of implementing a revised Safe and Just Culture policy, which addresses holding individual staff accountable within their job responsibilities and memorializes DHS' core values. Additionally, DHS has released updated Discipline Guidelines for distribution to all staff. The guidelines include specific language on staff accountability and consequences for failing to follow established policies.

ORGANIZATIONAL STRUCTURE

Tasks 5 and 6: Quality Improvement and Patient Safety (QIPS) section should report to the DHS Director and develop a plan that addresses QIPS' staffing issues. The status and implementation highlights for the noted organizational structure tasks are as follows:

- Task 5 Underway – Placement of QIPS Section: DHS and CEO are assessing the placement of QIPS within the DHS organizational structure. Task Completion is targeted for February 2011 to provide an opportunity for the DHS Director designee to provide input on this matter. However, a recommendation may be made prior to February.

- Task 6 Underway – QIPS Staffing Plan: A staffing plan is underway to address QIPS' staffing issues related to workload and expanded work responsibility. QIPS

does not have the necessary staff to perform the proposed functions identified in several of the Plan tasks. DHS is finalizing their staffing plan and preliminary estimates indicate a cost of approximately $1.0 million dollars. The staffing plan will be finalized and any additional position recommendations will be subject to your Board's approval. It should be noted that the implementation of the staffing plan will pose a financial challenge to DHS due to their budget deficit. Task 6 is targeted for December 2010.

SUMMARY

DHS has made significant progress in the reduction of medical malpractice and improved patient safety. To continue to build upon DHS' efforts, your Board called for the development of a detailed Medical Malpractice and Risk Management Study Implementation Plan (Plan) to implement 11 tasks that addressed areas in patient safety, policy and procedure, and organizational structure.

Work on the Plan has been initiated and three of the 11 tasks have been completed, six are targeted for completion before the end of 2010, and the two remaining tasks are scheduled to be completed by April 2011. The acquisition of the patient safety trend database system and the implementation of the staffing plan will pose a financial challenge to DHS due to their budget deficit.

We will continue to support DHS' leadership, provide guidance, and monitor the department's implementation efforts. DHS will provide your Board with status reports until all tasks have been fully implemented, and the next report is targeted for December 27, 2010.

If you have any questions, please contact me or your staff may contact Sheila Shima, Deputy Chief Executive Officer, at (213) 974-1160 or sshima@ceo.lacounty.gov.

WTF:BC:SAS
MLM:AMT:gl

Attachment

c: Executive Office, Board of Supervisors ✓
       County Counsel
       Health Services

ATTACHMENT

County of Los Angeles – Department of Health Services (DHS)
Medical Malpractice and Risk Management Study
Quality Improvement and Patient Safety (QIPS)

DHS IMPLEMENTATION PLAN

Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
1.	Develop a system to ensure we are "closing the loop" with corrective action plans (CAPs - system that ensures DHS tracks the implementation and effectiveness of CAPs across each of the facilities. *Relates to tasks: 3, 4, 6, and 7.*	DHS-Chief Medical Officer (CMO) QIPS-Leadership DHS-Facility Leadership	"Closing the loop" refers to ensuring corrective actions (CAs) listed in the CAPs and the associated system-wide surveys are validated as "implemented" once the corrective action process has been completed. • QIPS staff will conduct on-site audits to confirm CAs were implemented and correct the issue they were intended to address or, if modified, what the modification is and if modifications correct the issue. If the modification is identified as a best practice, it will be shared system-wide, and QIPS staff will work directly with facility staff assigned to this function. • The process will be recorded and tracked using a tracking database. • Approximately 20 new cases/CAPs are opened each month. The new cases will require survey assessments, tracking implementation, and audits.	10/2010	Completed
2.	Develop a database to track patient safety trends among all health facilities, including a patient safety dashboard that is published and monitored. *Relates to tasks: 8, 9, 10, and 11.*	DHS-Information Technology (IT) DHS-QIPS Leadership DHS-Facility Leadership	*Staffing needs are furthered discussed under Task 6.* DHS has been developing a clinical RM system to track patient safety trends among the health facilities. The system should track cases/events, corrective actions, surveys, associated staff, etc., and it may be designed in-house or purchased from outside vendor. Phase I included assessment and development of design plan; Phase II included system acquisition and implementation.	Phase I: 12/2010 Phase II: TBD	Phase I: Underway

County of Los Angeles – Department of Health Services (DHS)
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DHS IMPLEMENTATION PLAN

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Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
			Phase I – Assessment and design plan:		
			• Plan developed and includes all DHS' requirements; it was prepared in format that could be easily adapted to a Request for Proposal (RFP) or sole source option should solution not be available.		
			• Met with DHS IT Governance Committee; in-house staff and consultant do not have IT solution.		
			• Conduct review of commercially available systems to determine if pre-packaged products can meet DHS needs.		
			Phase II - acquire and implement the system. A challenge of acquiring a system includes DHS' budget deficit.		
3.	*Develop plan to reduce unnecessary bureaucracy to ensure CAPs are completed and implemented faster after an event.* *Relates to tasks: 1, 4, 6, and 7.*	DHS-CMO DHS-QIPS Chief Executive Office (CEO)-Risk Management (RM)	Conduct assessment of the current reviews and processes conducted by DHS' Audit and Compliance (A&C) and CEO-RM, and identify ways to streamline the process and process CAPs faster. • Analysis indicated that the reviews conducted by A&C and CEO-RM are different, necessary, and there is little overlap. • However, analysis did note that the A&C and CEO-RM review processes were sequential thereby prolonging the review process. The process has been revised and reviews are now conducted concurrently.	9/2010	Completed

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DHS IMPLEMENTATION PLAN

Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
4.	*Develop plan to ensure better coordination between patient safety staff at clinic sites and DHS staff so that system-wide initiatives are understood and implemented equally at each of the facilities.* ***Relates to tasks: 1, 3, 6, and 7.***	DHS-CMO DHS-QIPS Leadership DHS-IT DHS-Facility Leadership	Assessment indicated that there are several committees and groups within DHS which oversee various areas of responsibility; oversight fragmentation has occurred and groups work in relative silos. Additionally, system-wide initiatives are not always fully understood and/or implemented. DHS is proposing the re-structuring and creation of a committee (Phase I) as well as an educational program (Phase II) that standardizes the curriculum of basic patient safety education. ***Phase I - DHS-Quality, Patient Safety and Clinical Risk Reduction Committee:*** composed of medical staff and formed under evidence code 1157. *Committee also discussed under Task 6.* • Set organizational priorities for quality, patient safety, and clinical risk reduction/management, coordinate and oversee the function of the various DHS committees and groups, and would be composed of leaders or representatives from: Patient Safety Committee - responsible for organization-wide patient safety initiatives; Quality Improvement Committee - oversees quality measures (Core Measures, CHART, SCIP, etc); Medication Safety Committee - responsible for review of organizational medication safety trends and identification of best practices and policies; Best Practices Committees - encourages process improvements in Emergency Departments, Intensive Care Units, Infection Prevention, and Anesthesiology; Clinical Risk Management Committee - coordinates issues specific to limiting risk exposure; and QIPS - supports Executive Peer Review and CAPs that interface with	Phase I: 11/2010 Phase II: 4/2011	Underway Underway

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DHS IMPLEMENTATION PLAN

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			• patient safety, quality, and risk management. • Ad-hoc members would be added as needed for specific issues. • This Committee will look at clinical risk reduction in a coordinated, multidisciplinary fashion to ensure compliance within various areas of DHS for system-wide coordination in defining goals, fostering the implementation of organizational initiatives in quality and patient safety, and assessing effectiveness across our system. • Responsible for the Quality/Patient Safety Dashboard and website. • Responsible for "closing the loop" and reducing bureaucracy related to CAPs by providing a tracking mechanism to help ensure compliance across facilities. • Essential that such a committee, with its wide-ranging responsibilities, is chaired by a respected leader with the responsibility and authority to direct implementation of agreed-upon decisions. The work product of this committee, and its leader, should be accountable to, and supported by, DHS at the highest level. The proposed chair is the DHS CMO.		

County of Los Angeles – Department of Health Services (DHS)
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Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
		DHS-A/Director DHS-CMO	**Phase II - Educational Program:** uniformed, standardized curriculum of basic patient safety education. • Satisfactory completion of the core curriculum module would be required for all licensed clinical staff in DHS facilities (including but not limited to house staff, attending physicians, nurses, and appropriate technologists/other allied health professionals). • Curriculum would be developed and regularly updated under the supervision of the DHS Patient Safety Committee and would include, at a minimum, topics that are required by government (e.g. CDPH), other regulatory agencies (e.g. The Joint Commission), Board of Supervisors mandates, and additional issues that are important to DHS and individual facilities. • Optimally, a web-based electronic format will be utilized as it would facilitate presentation, expedite updating process, and automatic tracking and documentation of course completion. The module will be available in paper format to accommodate those areas where an electronic format is unavailable.	2/2011	
5.	Adopt Abaris' recommendation to have Quality Assurance staff report to the DHS Director instead of the Medical Director.	CEO	CEO is working with DHS-Acting Director and CMO in the assessment and placement of QIPS within the DHS structure. It should be noted that completion of this item is noted as February 2011 in order to provide an opportunity for the new DHS Director to provide input on this matter. Recommendation may be made prior to the noted date.		Underway

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DHS IMPLEMENTATION PLAN

Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
6.	*Develop plan to address QIPS' staffing issues to resolve problems of expanding responsibilities, overwork, and demoralization.* *Relates to tasks: 1, 3, 4, and 7.*	DHS-CMO DHS-QIPS Director	As noted under Task #1 "closing the loop," approximately 20 new cases/CAPs are opened each month. Based on the expanded role requested for CAPs and surveys, additional staffing will be required for audits and implementation oversight. As of 10/10, an existing backlog included approximately 650 CAPS and 660 surveys. The projected QIPS and facility staffing needs are noted below and will permit QIPS to operate in a manner that helps it address the current level of work and the additional work under the "closing the loop" requirement. However, the proposed staff does not take into account the existing backlog. The QIPS operation will focus on staying abreast of the current cases and moving them forward, and will work through the backlog as quickly as possible. The staffing plan is underway and preliminary estimates indicate a cost of $1.01M. As soon as the plan is finalized, targeted for 12/2010, it will be submitted to the CEO. Proposed staff include: • 3 Registered Nurses (one for each acute care hospital to conduct surveys, assess status of corrected actions, and ensure corrective actions are sustained, in collaboration with the HFCN); • 3 Health Facility Consultant, Nurses – HFCN (work with facility staff, consult with ambulatory care risk management, and assist with facility patient safety audits; and • 1 Assistant Nursing Director (oversee/ensure CAP implementation and "close the loop" processes.	12/2010	Underway

County of Los Angeles – Department of Health Services (DHS)
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DHS IMPLEMENTATION PLAN

Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
7.	*Develop policy to ensure all future CAPs hold physicians and other medical staff responsible when they fail to follow established policies where patients are harmed as a result.* **Relates to tasks: 1, 3, 4, and 6.**	DHS-CMO DHS-QIPS	Accountability measures and disciplinary guidelines are contained within DHS policy 311.202, Safe and Just Culture policy, and Discipline Guidelines. DHS will review noted policy and guidelines and update as appropriate. • DHS policy 311.202 includes specific language that holds all departmental staff accountable, no changes were identified. • Safe and Just Culture requires updating, input was obtained prior to approval and addresses holding individual staff accountable for own performance in accordance with their job responsibilities and DHS core values. Disciplinary action may be taken (in concert with County Employee Evaluation and Discipline guidelines) for: behavior that knowingly puts patients, visitors or staff at risk of harm; a conscious disregard for organizational policies, and procedures; behavioral choices that are disruptive to the workplace environment; and repetitive errors or repetitive at-risk behaviors that demonstrate an inability to fulfill legitimate work requirements. • DHS Discipline Guidelines were revised and include specific language about staff and consequences for failing to follow established policies. • Revised policy and guidelines were drafted and circulated for review and input prior to approval.	10/2010	Completed

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Task #	Task	Task Lead/s	Implementation Strategy/Comments	Target Completion	Status
8.	Support DHS' efforts to create a public "Quality and Patient Safety" website *Relates to tasks: 2, 9, 10, and 11.*	DHS	QIPS has been developing a Quality and Patient Safety website for some time and to complete this very important effort it anticipated presenting a draft public domain "Quality and Patient Safety" website to Public Patient Advocate (PPAs) stakeholders to obtain their input. Highlights include quality and patient safety activities within DHS, and presentation of data related to State and national benchmarked quality measures. • Integrated PAA's suggestions into dashboard and committed to providing a follow-up presentation prior to going live. • Website presented to: PPAs (Community Health Councils and Neighborhood Legal Services) 9/20; Hospital Commission 10/7; and Health Deputies 10/20. • Go-live date: 11/15/10.	11/2010	Underway
9.	Where applicable, define our goal and compare the quality measurements used to evaluate each County hospital against established State and national standards. *Relates to tasks: 2, 8, 10, and 11.*	DHS-CMO DHS-QIPS DHS-Facility Leadership	Review and assess current quality, risk and patient safety structure, identify structural and/or procedural changes as may be necessary. • QIPS proposed the creation of the *DHS-Quality, Patient Safety and Clinical Risk Reduction Committee*, composed of medical staff and formed under evidence code 1157. Committee will set organizational priorities for quality, patient safety, and risk management issues and will coordinate and oversee the function of the various committees and groups that currently work in relative silos.	11/2010	Underway

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			• Committee will measure hospital specific and aggregate data against national, State and benchmark affiliates where a source is available.		
			• Quality Improvement Committee provided input on transition plan prior to implementation.		
			Quality, Patient Safety and Clinical Risk Reduction Committee also discussed under Task 4.		
10.		DHS-CMO DHS-QIPS	Identify PPAs to help with the content presentation of the DHS dashboard that is under development. • Present draft dashboard to PPAs; and share with facility Quality Committee/staff for review and input. Schedules sessions for feedback/input on dashboard before going live. • Website presented to: PPAs (Community Health Councils and Neighborhood Legal Services) 9/20. • Go-live date: 11/15/10.	11/2010	Underway
	Convene focus group of patient care advocates to help develop the presentation of the dashboard data so that it is clear, understandable, and timely with a narrative that explains in lay person's language the significance of the data presented and actions taken should we ever fall below acceptable standards. ***Relates to tasks: 2, 8, 9, and 11.***				

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11.	*Promote the concept that public reports must be designed to be meaningful to lay people as well as professionals and to use said focus group to guide DHS in that direction.* *Relates to tasks: 2, 8, 9, and 10.*	DHS-CMO DHS-QIPS Director	Develop and implement a core set of principles to guide the presentation and development of public reports. Engage PPAs in the development of principles. • Dashboard goals: 1. Increase transparency; 2. Increase accountability for services provided; 3. Demonstrate the quality of services provided; 4. Catalyze a quality and patient safety culture; and 5. Facilitate healthcare choice for our population. Guidelines for selection and presentation of quality and patient safety measures for DHS' dashboard: 1. Measures must be reliable, valid and endorsed by a recognized national or state healthcare quality consensus body, such as the National Quality Forum (NQF) or the California Hospital Assessment and Reporting Taskforce (CHART); 2. Measures must provide the opportunity to evaluate our services against established state and national standards; 3. Measures must be actionable for providers in order to foster taking steps to improve patient care; and 4. Measures should be evaluated on an annual basis to ensure they meet the established goals. Measures should be updated as necessary if the dashboard goals listed above are consistently not met or it is discovered that the data is no longer valid.	11/2010	Underway

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			• Basic tenets: 1. Dashboard must be meaningful to lay people as well as professionals using lay people's language; and 2. Dashboard development will involve PPAs to ensure that it is understandable to the lay person. • DHS met with PPAs to discussed goals, principles, and basic tenets, and their input was incorporated. • DHS will monitor and update core principles as necessary.		